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SECOND UNITED NATIONS CONFERENCE ON THE LEAST DEVELOPED COUNTRIES:

Preparatory process for the Conference

LEAST DEVELOPED COUNTRIES AND HEALTH IN THE 1990s CHALLENGES AND PROPOSALS FOR ACTION*/

Contribution by the World Health Organization

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LEAST DEVELOPED COUNTRIES AND HEALTH IN THE 1990s

CHALLENGES AND PROPOSALS FOR ACTION

A paper by the World Health Organization in preparation for the Second United Nations Conference on LDCs

THE CHALLENGE

As the consequence of widespread and dramatic deterioriation in the last ten years of the economic and social situation of the majority of people living in the Least Developed Countries, a large proportion of the population, particularly in rural areas, is still without the barest necessities of life such as safe drinking water, hygienic shelter, essential health care, adequate food and a minimum level of economic productivity. Health services in recent years in LDCs have declined in quality, particularly at peripheral levels, and there no progress has been made in reducing social inequity, particularly between urban and rural areas, in the availability, accessibility and quality of health care provided.

As LDCs enter the 1990s there is an urgent need for action on multiple fronts that will lay the foundation for future changes - changes that can bring about growth and the reduction of poverty.

The essential building blocks of this foundation are the children, women and men of the LDCs. Growth and development starts with and ends with people.

They must be active partners in their country's quest for future growth and development. To do so they must be healthy, well-nourished, educated and sheltered. The challenge of the 1990s for the LDCs and for the world as a whole will be to meet the basic needs of these children, women and men in health, nutrition, education and housing.

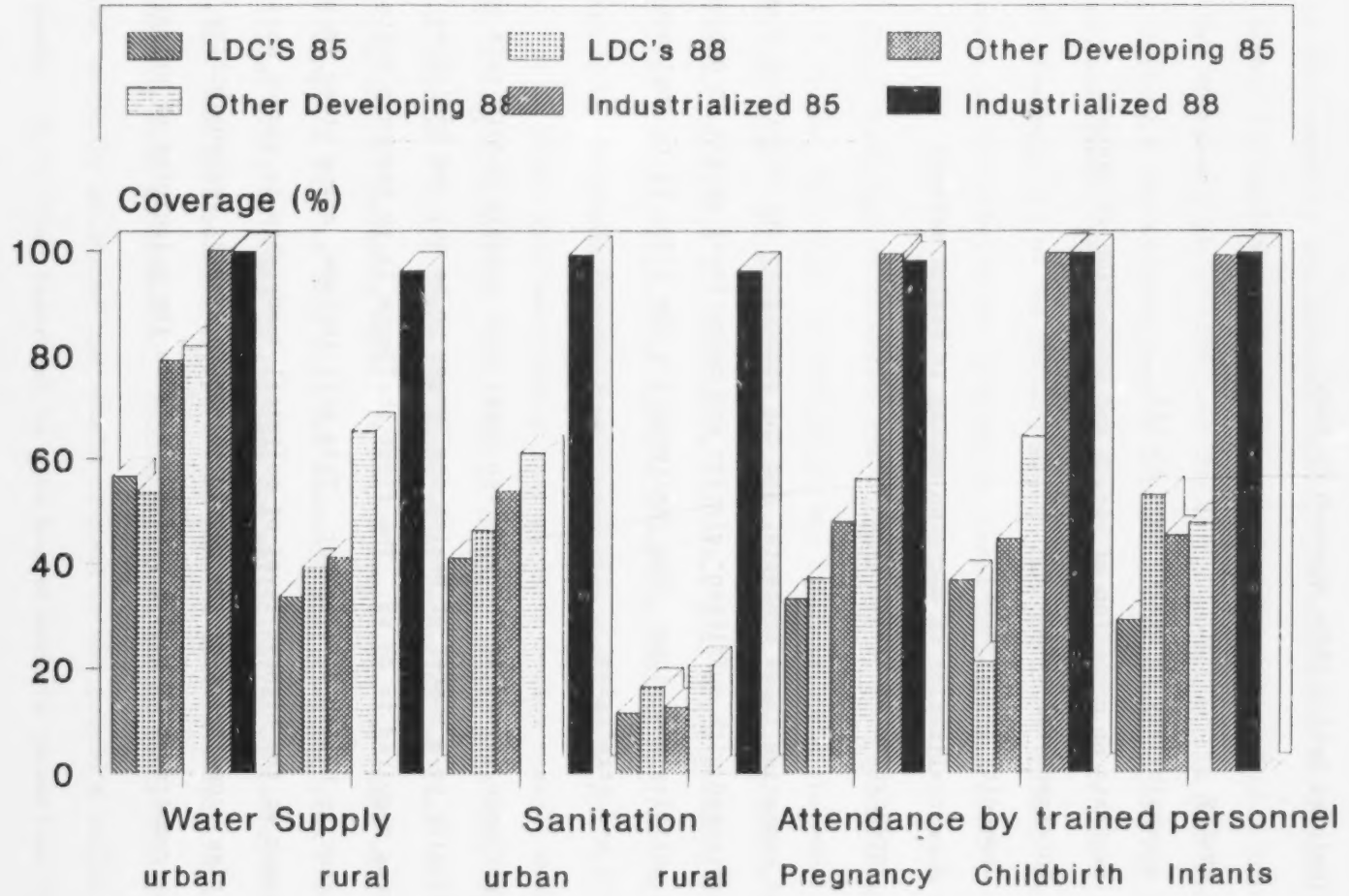
Meeting basic needs in health continues to elude LDCs. During the 1980s there has been a decrease in the supply of and an increase in the demand for health services. This imbalance is unacceptable. The gap in health status (as shown by selected indicators (see graph overleaf)) between LDCs and other developing countries on the one hand and developed countries on the other reflects this. To close this gap, it is clear that the 1990s call for considerable investment in health in least developed countries.

In the decade ahead the concepts and principles of primary health care, as envisaged by governments in Alma-Ata in 1978 and recently reaffirmed at Riga, USSR in March 1988, remain viable. The essential elements of primary health care include:

1) information and education concerning health
2) promotion of food availability and proper nutrition
3) water and sanitation
4) maternal and child health
5) immunization

READEX FICHE

Weighted average of selected indicators
1985- 1988



6) prevention and control of endemic diseases

7) treatment of common diseases and injuries

8) provision of essential drugs.

The principles behind this approach include:

1) equity

2) accessibility to health care by all

3) emphasis on promotion of health and prevention of disease

4) intersectoral action

5) community involvement

6) decentralization of decision-making in health matters

7) integration of health programmes.

In most countries these concepts, and the strategies for attaining them, have been expressed with sufficient clarity and operational detail in national health policies and plans. The challenge for the 1990s is to implement these policies and strategies.

Experience gained in the past ten years with primary health care points specifically to a number of health challenges to be met and indicates the resources required to do so. The first challenge is to ensure a sustained commitment to health development. This will include, among other factors, commitment at the highest level of political leadership to reduce social inequities; commitment of the people to assume greater responsibility for their health; commitment of health professionals to the principles of primary health care.

The second challenge is the need to intensify efforts to strengthen the health infrastructure, based on the principles of primary health care. This will require particular attention to adequate manpower, skills, technology, resources (at each level of care) and referral systems. Particular emphasis is needed at the community and district levels. The effects of population growth and the demand for health care resources are already great and will continue to be so. New diseases such as AIDS, and the recrudescence of old ones such as malaria, influence the existing health infrastructure. Many countries, at all levels of development, do not fully realize or take advantage of the cost-effective measures of the primary health care approach; in many countries, for example, over-concentration on hospital-based care has increased.

The third challenge is to ensure the optimum use of all resources available for health (human, material, technological and financial) and the mobilization of additional ones. There is still a large gap in the spending levels for health between developed and developing countries and, while spending levels alone are not the only measure of efforts needed to improve health levels, there should be a minimum threshold that countries ought to be able to sustain. It is clear that maintaining past gains in health status, especially in least developed countries, will require resource levels of a much higher magnitude that at present. For the majority of countries (at least 65% of the world's population) spending levels on health are within the range of 1%-3% of GNP. Finding new ways to cope with new economic realities requires creativity and political skill in order to increase the participation of individuals and communities, non-governmental organizations and the private sector in a spirit of partnership with governments. Health personnel should be technically qualified, socially motivated and should respond to the people's health and social needs. It is also important to give health workers incentives to

deliver good care economically. Strengthening of health research and development will be a very significant form of support for the implementation of national health strategies.

The fourth challenge is to intensify efforts to strengthen managerial capabilities including measures to ensure sound decisions and policies, with a sharper focus on priorities and targets based on valid information. National capacities for assessing and projecting health needs and tasks on a continuing basis, as well as for developing or reorientating health strategies and programmes, and for the monitoring and evaluating of their progress and outcome, will require considerable strengthening. The capacity of ministries of health to carry out an economic analysis of health choices will need enhancing.

Looking ahead to the coming decade, the real resources required for the health sector and for related health actions will be significantly greater than in the past decade. There is an optimum amount that countries and individuals should spend so as to maximize health improvements, but it is difficult, if not impossible, to quantify with precision that figure. On a world average scale, less than 5% of GNP is spent on health care services, with some countries at close to 12% and others at less than 2%. As a minimum, in the next decade, the percentage of GNP devoted to health should probably be doubled in some countries. Much of this increase should be for previously neglected health problems presenting a heavier socioeconomic burden for society. In the affluent countries, historic rates of economic growth will generate sufficient resources in the future, although even there reforms in delivery and finance systems will be necessary. In the poor and developing countries, a shift in priorities with more emphasis on primary health care would help liberate some

of the resources needed. Reforms of financing and delivery systems would also result in internal resources becoming available for reallocation towards priority health concerns. However, for human development and health levels to increase over the next decade in the least developed countries it will require favourable world economic conditions and major reforms in management, delivery and financing. In addition, LDCs will require adequate additional, external financial assistance for the foreseeable future.

IMPLEMENTING PRIMARY HEALTH CARE: PROPOSALS FOR ACTION IN THE 1990s

The basic strategic health objectives for the 1990s continue to be the attainment of targets set and adopted by governments at Alma Ata in 1978 and reaffirmed at Riga, USSR in 1988. Detailed analysis of global indicators for monitoring the progress toward the achievement of these targets, based on information provided by the countries themselves, is set out in Annex 1.

Achieving the effective implementation of primary health care requires partnership among least developed countries, the World Health Organization and the members of the international community. It is essential that each partner in this cooperation takes specific responsibilities and action.

ACTIONS BY THE LDCs

Health should be considered as everyone's business. This will require political commitment at the highest level including ministries of planning and finance as well as the ministries of education and health. An enabling environment that promotes effective and efficient health care delivery

including appropriate incentives and building up a physical infrastructure must be created. This building of capacity and investing in people to improve the delivery of health services will be essential. While developing this capacity, the process of decentralization within the decision-making system to increase responsiveness to the needs of the people and facilitate local participation in planning and implementation of activities should be stressed. While recognizing the special economic characteristics of the health sector, it should be perceived as an economically productive sector and as such should be able to compete for adequate government domestic resources. Finally, having developed the appropriate priorities and strategies, the government should ensure that all external partners collaborate within this framework to ensure that external inputs would best complement domestic expenditure.

ACTIONS BY DONOR GOVERNMENTS

It must be recognized that LDCs will require adequate additional external financial support on a long-term basis and that fundamental changes in aid modalities for the health sector are required, both to limit LDC dependence and to increase the effectiveness of aid.

International policies could be developed to ensure that both multilateral and bilateral partners work within a common framework to strengthen governments in attaining their health sector priorities. Joint programming by donors in full consultation with the government and in coordination with the World Health Organization would improve aid coordination. In order to improve intersectoral technical cooperation to absorption, local and recurrent cost support should be increased. The role of NGOs in enhancing absorptive capacity should be recognized.

External assistance should be consistent and continuous. Multiple year programming of assistance would help to improve predictability.

ACTIONS BY WHO

WHO has launched a new initiative aimed at overcoming the obstacles to the effective implementation of primary health care, where the concentration of effort is on countries and peoples in most need.

This initiative, which is country focused, emphasises better integration and coordination of all WHO programmes within a country, together with close alignment of WHO activities with the national priorities in health. It also lays special stress upon the need to support countries in developing an increased capacity to deal with the analytical, management, economic and financial aspects of health strategies.

Inherent in the WHO approach is a commitment by the national authorities of the country concerned to take a fresh and realistic look at their health priorities and available resources, and to do this within the concept of starting from a zero base. The government concerned must be prepared to recast its national health plans, or to vary them, and to reallocate existing resources, if the reappraisal shows this to be necessary.

At the same time, WHO in consultation with the government concerned must commit itself to a re-examination of the allocation pattern of its own resources, with a view to ensuring appropriate redeployment of such resources as required.

The outcome of this process will naturally vary from country to country. However, in most cases it can be anticipated to lead to the development of better integrated, well coordinated and more realistic national health development plans, as well as health systems and infrastructure development, which face up to the realities of the availability of human and financial resources.

In pursuing the new initiative, each of the WHO organizational levels (global, regional and country) has a vital and complementary role to play. While headquarters retains responsibility for overall policy, provides appropriate technical support together with the regional offices, and plays a major role in seeking and coordinating additional resources for the initiative, the regional offices are the crucial focus for the coordination and management of the ongoing activities of the initiative within the countries of their regions. Within each country the role of the WHO representatives (WR), as coordinators of all WHO in-country programmes, is of utmost importance for the success of the new endeavour. WHO is exploring ways of strengthening the capacity of the Office of the WR to support more effectively the ministry of health in technical areas and play a full and active role as coordinator in the international health field. The new initiative, with its emphasis on better integration at country level and on a more effective WHO country office, offers an excellent launch-pad for more effective and mutually beneficial working relationships at country level between WHO and cooperating agencies.

An important result of the activities under the initiative will be an increased capacity for planning, programming and management in the health sector. This will, of course, be of direct benefit to the countries concerned, but it will also provide a guarantee of a greater capacity to absorb, and to use effectively, resources provided, both from other cooperating organizations and WHO.

In summary, the development by the national authorities, of rational, realistic and coherent health plans, taking into account the realities of resource availability, provides a logical framework with which resources will be used more effectively and as part of the overall development process of the country.

Throughout the process described above, the Organization will maintain, at all levels, a close working partnership with multilateral and bilateral development cooperation agencies. Inherent in the new approach is the recognition of the government as the national body responsible for the coordination of external cooperation in the health field and for the integration of such cooperation into a cohesive national plan. WHO will cooperate with ministries in strengthening their capacity in this respect. Emphasis should be placed on the definition of a framework for cooperation which would be based on the national health plan and would include an analysis of the conditions required by all partners involved as well as an evaluation scheme. Governments should be supported in ensuring that all external partners then operate within that framework. The objective is to mobilize appropriate national and external resources to fill any identified resource gap and thus ensure that priority programmes and activities are financed. WHO should

support governments in developing an analytical ability to forecast resource needs, to justify these needs, to predict resource availability and to assess the impact and effectiveness of cooperation received. The Organization should also support governments in their efforts to mobilize resources and coordinate aid by such means as helping to develop a health cooperation strategy and participating in the relevant negotiations, and through the provision of technical and logistic support for meetings with the financing agencies.

This initiative for intensified cooperation with countries should result in cooperation in health being more effective, efficient, timely and appropriate to the problems of each country. There is, at present, no other choice in the global endeavour to meet the challenge posed by the persistance of high mortality and preventable morbidity in least developed countries. Through a better integrated and more sharply focused approach to primary health care implementation by countries, WHO and the international community will open the door to significant advances in the health status of the peoples in least developed countries.

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Annexe 1

COUNTRY OR AREA	Immunization of infants								Immunization of pregnant women	
	DPT		Measles		Poliomyelitis		BCG		tetanus (2d)	
	1985	1988	1985	1988	1985	1988	1985	1988	1985	1988
AFGHANISTAN	15	25	14	31	15	25	17	27	11	6
BANGLADESH	2	9	1	6	2	8	2	14	2	7
BENIN	17.0	52.0	23.0	38.0	16.0	52.0	27.0	67.0		8.0
BHUTAN	10	27	11	23	11	27	21	38	3	10
BOTSWANA	68.0	86.0	68.0	91.0	68.0	88.0	68.0	99.0		40.0
BURKINA FASO		34.0	38.0	68.0		34.0	17.0	67.0	4.0	26.0
BURUNDI		73.0		58.0		76.0		89.0	18.0	49.2
CAPE VERDE		45.0		59.0		58.0		99.0		0.0
CENTRAL AFRICAN REPUBLIC	20.0	24.0	23.0	30.0	20.0	24.0	34.0	53.0		20.0
CHAD		13.0		16.0		13.0		31.0		15.0
COMOROS		71.0	18.0	71.0		73.0		97.0	10.0	26.0
DEMOCRATIC YEMEN	7	25	14	35	7	25	17	41	3	8
DJIBOUTI	30	60	27	61	30	60	58	42	10	10
EQUATORIAL GUINEA	3.0	3.0	12.0	11.9	4.0	4.1		29.1	17.0	16.8
ETHIOPIA	6.0	16.0	12.0	13.0	6.0	6.4	11.0	27.0	4.0	7.0
GAMBIA	77.0	77.0	75.0	82.0	55.0	83.0	92.0	90.0	83.0	85.0
GUINEA		1.6		9.4		0.7		5.6		6.7
GUINEA-BISSAU	18.0	56.0	35.0	60.0	18.0	54.0	33.0	98.0	10.0	22.0
HAITI	19	28	21	23	19	28	57	45		31
KIRIBATI	37	37	7	7	15	15	49	49		2
LAO PEOPLE'S DEMOCRATIC REPUBLIC	28	71	33	70	28	71	8	77		62
LESOTHO		77.0		79.0		77.0		84.0		0.0
MALAWI	52.0	55.0	51.0	53.0	46.0	50.0	87.0	92.0	18.0	20.0
MALDIVES	3	6	30	9	5	6	52	60	15	2
MALI		3.0		5.0		3.0		15.0		3.0
MAURITANIA		32.0		69.0		61.0		91.0	12.0	0.0
MOZAMBIQUE	29.0	29.0	39.0	39.0	25.0	25.0	47.0	47.0	40.0	40.0
MYANMAR	16	23		14	3	13	45	45	20	24
NEPAL	31	46	45	0	20	40	67	78	10	15
NIGER		5.0		0.0		0.0		0.0		2.9
RWANDA	50	67	52	78	56	86	83	92	21	0
SAMOA	92	89	89	81	92	93	97	97		21
SAO TOME AND PRINCIPE	42	66	35	59	45	65	75	90	42	59
SIERRA LEONE		30		50		30		73		59
SOMALIA	22	25	34	29	22	25	31	33	14	6
SUDAN	8	29	6	22	8	29	12	46	3	12
TOGO		41		48		40		66		64
TUVALU	97	58	92	65	97	73	99	92		13
UGANDA	14	39	17	48	13	40	37	74	5	13
UNITED REPUBLIC OF TANZANIA	67	81	74	88	64	65	90	94	37	54
VANUATU	30	31	26	25	27	31	83	75		16
YEMEN	10	14	11	15	10	14	20	28	3	2

COUNTRY OR AREA	Birth related attendance by trained personel					
	Pregnancy		Childbirth		Infants	
	1985	1988	1985	1988	1985	1988
AFGHANISTAN	5.0	8.0	5.0	8.0		
BANGLADESH		12.0		5.0		
BENIN	27.2	63.7	34.3	44.6		
BHUTAN	3.4	16.0	3.4	7.0		38.0
BOTSWANA		74.0		79.0		54.0
BURKINA FASO	40.0	10.3		30.0	30.0	20.0
BURUNDI	13.6	30.0	12.0	16.0	14.2	
CAPE VERDE	96.0	99.0	10.0		85.0	100.0
CENTRAL AFRICAN REPUBLIC		68.5		65.7		67.6
CHAD						
COMOROS	69.4	69.4	24.0	24.0		
DEMOCRATIC YEMEN	10.0	10.0	10.0	10.0		
DJIBOUTI	50.0	76.0	73.0	79.0	15.0	62.0
EQUATORIAL GUINEA						
ETHIOPIA	14.0		58.0	9.0	10.0	15.0
GAMBIA	90.0	90.0	80.0	54.0		
GUINEA		36.0		25.0		
GUINEA-BISSAU		29.0		38.7		92.5
HAITI	44.8	41.0	20.0	40.0		33.0
KIRIBATI						
LAO PEOPLE'S DEMOCRATIC REPUBLIC						
LESOTHO	40.0	50.0	28.0	40.0		80.0
MALAWI	73.8	37.0	58.6	45.0	64.0	98.0
MALDIVES	47.0					
MALI		20.0		16.0		
MAURITANIA	58.0	26.5	22.6	20.0	60.0	47.0
MOZAMBIQUE	46.0	43.0	28.0	30.0	17.0	23.0
MYANMAR	90.9	75.0	97.4	25.0		71.0
NEPAL	17.0	9.0	10.0	6.0	10.0	
NIGER	46.5		46.5		17.9	
RWANDA		85.0		22.0		
SAMOA	92.0	50.0	52.0	95.0	97.0	50.0
SAO TOME AND PRINCIPE	60.0	64.0		86.0	3.5	80.0
SIERRA LEONE	30.0		25.0		30.0	
SOMALIA	2.0	2.0	2.0	2.0		
SUDAN	20.0	40.0	20.0	60.0	70.0	70.0
TOGO						
TUVALU	100.0	100.0	100.0	100.0	100.0	100.0
UGANDA		86.0				
UNITED REPUBLIC OF TANZANIA	98.0	90.0	74.0	60.0		90.0
VANUATU	90.0	75.0	72.0	86.0		
YEMEN	21.0		12.0	12.0		

COUNTRY OR AREA	GNP per capita US$	
	1985	1988
AFGHANISTAN	202.0	205.0
BANGLADESH	123.0	147.0
BENIN	290.0	349.0
BHUTAN	80.0	110.0
BOTSWANA	648.0	1500.0
BURKINA FASO	240.0	200.0
BURUNDI	180.0	240.0
CAPE VERDE	341.0	
CENTRAL AFRICAN REPUBLIC	280.0	
CHAD	80.0	158.0
COMOROS	300.0	300.0
DEMOCRATIC YEMEN	408.0	430.0
DJIBOUTI	276.0	276.0
EQUATORIAL GUINEA	180.0	
ETHIOPIA	120.0	
GAMBIA	250.0	
GUINEA	300.0	320.0
GUINEA-BISSAU	160.0	200.0
HAITI	300.0	330.0
KIRIBATI	48.0	324.0
LAO PEOPLE'S DEMOCRATIC REPUBLIC	202.0	202.0
LESOTHO	623.0	400.0
MALAWI	262.0	170.0
MALDIVES	407.0	348.0
MALI	120.0	170.0
MAURITANIA	185.0	235.0
MOZAMBIQUE	270.0	105.0
MYANMAR	170.0	239.0
NEPAL	170.0	160.0
NIGER	240.0	250.0
RWANDA	236.0	301.0
SAMOA		299.0
SAO TOME AND PRINCIPE	264.0	
SIERRA LEONE	320.0	300.0
SOMALIA	290.0	270.0
SUDAN	375.0	105.0
TOGO	264.0	
TUVALU	360.0	334.0
UGANDA	230.0	164.0
UNITED REPUBLIC OF TANZANIA	270.0	270.0
VANUATU	529.0	115.0
YEMEN	530.0	520.0

COUNTRY OR AREA	Adult literacy rates			
	Males		Females	
	1985	1988	1985	1988
AFGHANISTAN	33.0	50.0	6.0	10.0
BANGLADESH	39.7		18.8	
BENIN	25.1		9.5	
BHUTAN	36.8	36.8	10.0	10.0
BOTSWANA	32.0	62.0	36.0	64.0
BURKINA FASO	18.0	16.6	5.0	6.3
BURUNDI	35.4	46.0	15.7	35.0
CAPE VERDE	54.0		34.0	
CENTRAL AFRICAN REPUBLIC				
CHAD	35.0		8.0	
COMOROS		56.3		41.5
DEMOCRATIC YEMEN		59.0		25.0
DJIBOUTI	34.0	34.0	14.0	14.0
EQUATORIAL GUINEA				
ETHIOPIA				
GAMBIA		20.0		20.0
GUINEA	35.0		14.0	
GUINEA-BISSAU				
HAITI		40.0		35.0
KIRIBATI				
LAO PEOPLE'S DEMOCRATIC REPUBLIC				
LESOTHO		50.0		50.0
MALAWI	48.0	52.0	25.0	31.0
MALDIVES	81.5		81.8	
MALI	19.0		8.0	
MAURITANIA				
MOZAMBIQUE	44.2		12.3	
MYANMAR	86.0	85.8	76.0	71.6
NEPAL	31.7	51.8	9.2	18.0
NIGER	14.0		6.0	
RWANDA	49.5	61.0	30.5	33.0
SAMOA				
SAO TOME AND PRINCIPE	73.2		42.5	
SIERRA LEONE	31.0	32.0	17.0	25.0
SOMALIA	61.0	18.0	48.0	7.0
SUDAN	44.0	47.0	17.0	20.0
TOGO	33.0		20.0	
TUVALU				
UGANDA	63.0		38.0	
UNITED REPUBLIC OF TANZANIA			18.0	
VANUATU				
YEMEN	16.0	42.0	1.0	7.0

COUNTRY OR AREA	Population (in thousands) 1980	1985	1990
AFGHANISTAN	16,063	14,519	16,557
BANGLADESH	88,219	101,147	115,593
BENIN	3,494	4,050	4,741
BHUTAN	1,245	1,362	1,516
BOTSWANA	902	1,078	1,285
BURKINA FASO	6,959	7,882	9,007
BURUNDI	4,100	4,721	5,451
CAPE VERDE	296	330	379
CENTRAL AFRICAN REPUBLIC	2,298	2,576	2,913
CHAD	4,477	5,018	5,678
COMOROS	381	444	519
DEMOCRATIC YEMEN	1,861	2,137	2,491
DJIBOUTI	300	350	406
EQUATORIAL GUINEA	352	392	440
ETHIOPIA	38,750	42,271	46,743
GAMBIA	641	745	858
GUINEA	5,407	6,075	6,876
GUINEA-BISSAU	809	889	987
HAITI	5,413	5,922	6,504
KIRIBATI	59	64	68
LAO PEOPLE'S DEMOCRATIC REPUBLIC	3,205	3,594	4,071
LESOTHO	1,339	1,538	1,774
MALAWI	6,091	7,141	8,428
MALDIVES	155	183	215
MALI	7,023	8,082	9,362
MAURITANIA	1,551	1,766	2,024
MOZAMBIQUE	12,100	13,720	15,663
MYANMAR	33,821	37,544	41,675
NEPAL	14,858	16,915	19,143
NIGER	5,311	6,115	7,109
RWANDA	5,163	6,102	7,232
SAMOA	155	163	170
SAO TOME AND PRINCIPE	85	97	112
SIERRA LEONE	3,263	3,665	4,151
SOMALIA	5,352	6,398	7,555
SUDAN	18,681	21,818	25,195
TOGO	2 554	2,960	3,455
TUVALU	8	8	9
UGANDA	13,119	15,491	18,442
UNITED REPUBLIC OF TANZANIA	18,867	22,751	27,328
VANUATU	117	142	164
YEMEN	5,995	6,888	8,017

COUNTRY OR AREA	Life expectancy - Males			Life expectancy - Females		
	1980-1985	1985-1990	1990-1995	1980-1985	1985-1990	1990-1995
AFGHANISTAN	40.0	41.0	43.0	41.0	42.0	44.0
BANGLADESH	49.1	51.1	53.1	48.1	50.4	52.6
BENIN	42.4	44.9	46.9	45.6	48.1	50.2
BHUTAN	46.6	48.6	50.6	45.1	47.1	49.4
BOTSWANA	53.0	55.5	58.0	59.0	61.5	64.0
BURKINA FASO	43.7	45.6	47.6	46.8	48.9	50.9
BURUNDI	44.9	47.4	49.3	48.1	50.7	52.7
CAPE VERDE	57.3	59.3	61.3	60.8	62.8	64.8
CENTRAL AFRICAN REPUBLIC	41.4	43.9	45.9	44.6	47.1	49.1
CHAD	41.4	43.9	45.9	44.6	47.1	49.1
COMOROS	48.3	50.3	52.2	51.7	53.8	55.8
DEMOCRATIC YEMEN	46.9	49.4	51.9	49.9	52.4	54.9
DJIBOUTI	43.4	45.4	47.4	46.6	48.7	50.7
EQUATORIAL GUINEA	42.4	44.9	46.9	45.6	48.1	50.1
ETHIOPIA	38.4	39.4	41.4	41.6	42.6	44.6
GAMBIA	39.4	41.4	43.4	42.6	44.6	46.6
GUINEA	38.7	40.6	42.6	41.8	43.8	45.8
GUINEA-BISSAU	41.4	43.4	45.4	44.6	46.6	48.7
HAITI	51.2	53.1	55.0	54.4	56.4	58.3
KIRIBATI						
LAO PEOPLE'S DEMOCRATIC REPUBLIC	44.5	47.0	49.5	47.5	50.0	52.5
LESOTHO	49.0	51.5	54.0	58.0	60.5	63.0
MALAWI	44.4	46.3	48.4	45.7	47.7	49.7
MALDIVES						
MALI	40.4	42.4	44.4	43.6	45.6	47.6
MAURITANIA	42.4	44.4	46.4	45.6	47.6	49.7
MOZAMBIQUE	42.9	44.9	46.9	46.1	48.1	50.2
MYANMAR	55.8	58.3	60.8	59.3	61.8	64.3
NEPAL	49.0	51.5	54.0	47.5	50.3	53.0
NIGER	40.9	42.9	44.9	44.1	46.1	48.1
RWANDA	44.9	46.9	48.8	48.1	50.2	52.2
SAMOA						
SAO TOME AND PRINCIPE						
SIERRA LEONE	37.5	39.4	41.4	40.6	42.6	44.6
SOMALIA	41.4	43.4	45.4	44.6	46.6	48.6
SUDAN	46.6	48.6	50.6	49.0	51.0	53.0
TOGO	48.8	51.3	53.2	52.2	54.8	56.8
TUVALU						
UGANDA	47.4	49.4	51.4	50.7	52.7	54.7
UNITED REPUBLIC OF TANZANIA	49.3	51.3	53.3	52.7	54.7	56.7
VANUATU						
YEMEN	46.9	49.5	52.0	49.9	52.4	54.9

COUNTRY OR AREA	Infant mortality rates 1980-1985	1985-1990	1990-1995
AFGHANISTAN	183.0	172.1	162.4
BANGLADESH	128.2	119.2	107.5
BENIN	120.1	110.0	101.0
BHUTAN	138.7	128.2	118.2
BOTSWANA	76.0	67.0	58.0
BURKINA FASO	149.4	137.6	126.5
BURUNDI	124.1	111.9	102.7
CAPE VERDE	74.8	65.6	56.7
CENTRAL AFRICAN REPUBLIC	142.0	132.0	122.0
CHAD	142.8	132.0	122.0
COMOROS	88.3	79.8	71.7
DEMOCRATIC YEMEN	134.9	120.4	106.5
DJIBOUTI	132.0	121.6	111.9
EQUATORIAL GUINEA	137.3	127.0	117.0
ETHIOPIA	159.0	154.3	142.8
GAMBIA	154.3	142.8	132.0
GUINEA	159.1	147.4	136.2
GUINEA-BISSAU	142.8	132.0	121.6
HAITI	128.0	117.0	106.0
KIRIBATI			
LAO PEOPLE'S DEMOCRATIC REPUBLIC	122.5	110.0	97.0
LESOTHO	111.0	100.0	89.0
MALAWI	163.0	150.5	138.3
MALDIVES			
MALI	179.5	169.0	159.0
MAURITANIA	137.3	126.6	116.6
MOZAMBIQUE	153.5	141.5	130.1
MYANMAR	80.0	70.2	59.1
NEPAL	138.7	128.2	118.2
NIGER	145.7	134.6	124.1
RWANDA	132.0	121.6	111.9
SAMOA			
SAO TOME AND PRINCIPE			
SIERRA LEONE	166.5	154.3	142.8
SOMALIA	142.9	132.0	121.7
SUDAN	117.6	108.1	99.1
TOGO	102.3	93.8	85.3
TUVALU			
UGANDA	112.0	102.7	93.8
UNITED REPUBLIC OF TANZANIA	115.0	105.6	96.6
VANUATU			
YEMEN	129.9	115.7	102.3

COUNTRY OR AREA	Coverage with safe water (%)				Coverage with adequate sanitary facilities (%)			
	Urban		Rural		Urban		Rural	
	1985	1988	1985	1988	1985	1988	1985	1988
AFGHANISTAN	30.0	38.0	10.0	17.0		5.0		0.0
BANGLADESH	29.0	25.0	43.0	66.0	21.0	20.0	2.0	6.0
BENIN	45.0	79.0	9.0	34.5	45.0	60.0	4.0	10.0
BHUTAN	40.0	100.0	14.0	24.0		100.0		7.0
BOTSWANA	98.0	100.0	72.0	33.0	79.0	90.0	12.5	25.0
BURKINA FASO	50.0	0.0	26.0	0.0	38.0	38.0	5.0	5.0
BURUNDI	32.8	92.0	22.0	27.0	90.0	90.0	25.0	15.0
CAPE VERDE	99.0	100.0	21.0	49.0	36.0	41.0	9.0	0.0
CENTRAL AFRICAN REPUBLIC	24.0	0.0	5.0	0.0	36.0	0.0	9.0	0.0
CHAD	27.0	0.0	30.0	0.0		0.0		0.0
COMOROS	99.0	0.0	52.0	0.0		90.0		80.0
DEMOCRATIC YEMEN	73.0	86.0	39.0	35.0	69.0	70.0	33.0	30.0
DJIBOUTI	53.0	50.0	20.0	21.0	43.0	94.0	19.0	50.0
EQUATORIAL GUINEA	47.0	0.0		0.0	28.0	0.0		0.0
ETHIOPIA	93.0	0.0	42.0	0.0		0.0	5.0	0.0
GAMBIA	100.0	0.0	33.0	0.0		0.0		0.0
GUINEA	91.0	61.9	2.0	14.5	54.0	0.0	1.0	0.0
GUINEA-BISSAU	21.0	18.5	37.0	22.0	21.0	29.2	13.0	18.1
HAITI	73.0	59.0	25.0	32.0	54.0	42.0	12.0	14.0
KIRIBATI		0.0		0.0		0.0		0.0
LAO PEOPLE'S DEMOCRATIC REPUBLIC		0.0		0.0		0.0		0.0
LESOTHO	37.0	0.0	14.0	40.0	22.0	0.0	11.0	20.0
MALAWI	82.0	66.0	54.0	49.0		0.0		0.0
MALDIVES	53.0	91.0	8.0	17.0	69.0	100.0	1.0	2.1
MALI	58.0	48.0	19.7	17.0	90.0	100.0	5.0	0.0
MAURITANIA	80.0	0.0	16.0	0.0	7.0	0.0		0.0
MOZAMBIQUE	82.0	50.0	2.0	12.0		80.0		40.0
MYANMAR	36.0	37.0	21.0	27.0	34.0	35.0	15.0	26.0
NEPAL	71.0	77.0	11.0	24.0	16.0	54.0	1.0	1.0
NIGER	48.0	0.0	34.2	0.0	36.0	0.0	3.0	0.0
RWANDA	55.0	0.0	60.0	0.0	60.0	0.0	60.0	0.0
SAMOA		0.0		0.0		0.0		0.0
SAO TOME AND PRINCIPE		0.0		0.0		0.0		0.0
SIERRA LEONE	58.0	86.0	8.0	20.0	43.0	86.0	10.0	20.0
SOMALIA	60.0	57.0	20.0	22.0	60.0	44.0	5.0	5.0
SUDAN		90.0		20.0	20.0	40.0	1.0	5.0
TOGO	68.0	0.0	26.0	0.0	34.0	0.0	8.0	0.0
TUVALU	100.0	100.0	100.0	100.0				
UGANDA	45.0	45.0	12.0	12.0	40.0	40.0	10.0	10.0
UNITED REPUBLIC OF TANZANIA	85.0	80.0	47.0	38.0	91.0	90.0	76.0	78.0
VANUATU		0.0		0.0		95.0		35.0
YEMEN	100.0	90.0	21.0	30.0	75.0	66.0		0.0

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Intergovernmental Group on the Least
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Seventh session
(Preparatory Committee for the Second
United Nations Conference on the Least
Developed Countries)
Geneva, 26 March 1990

SECOND UNITED NATIONS CONFERENCE ON THE LEAST DEVELOPED COUNTRIES:

Preparatory process for the Conference

LEAST DEVELOPED COUNTRIES AND HEALTH IN THE 1990s CHALLENGES AND PROPOSALS FOR ACTION

Contribution by the World Health Organization

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LEAST DEVELOPED COUNTRIES AND HEALTH IN THE 1990s

CHALLENGES AND PROPOSALS FOR ACTION

A paper by the World Health Organization in preparation for the Second United Nations Conference on LDCs

THE CHALLENGE

As the consequence of widespread and dramatic deterioriation in the last ten years of the economic and social situation of the majority of people living in the Least Developed Countries, a large proportion of the population, particularly in rural areas, is still without the barest necessities of life such as safe drinking water, hygienic shelter, essential health care, adequate food and a minimum level of economic productivity. Health services in recent years in LDCs have declined in quality, particularly at peripheral levels, and there no progress has been made in reducing social inequity, particularly between urban and rural areas, in the availability, accessibility and quality of health care provided.

As LDCs enter the 1990s there is an urgent need for action on multiple fronts that will lay the foundation for future changes - changes that can bring about growth and the reduction of poverty.

The essential building blocks of this foundation are the children, women and men of the LDCs. Growth and development starts with and ends with people.

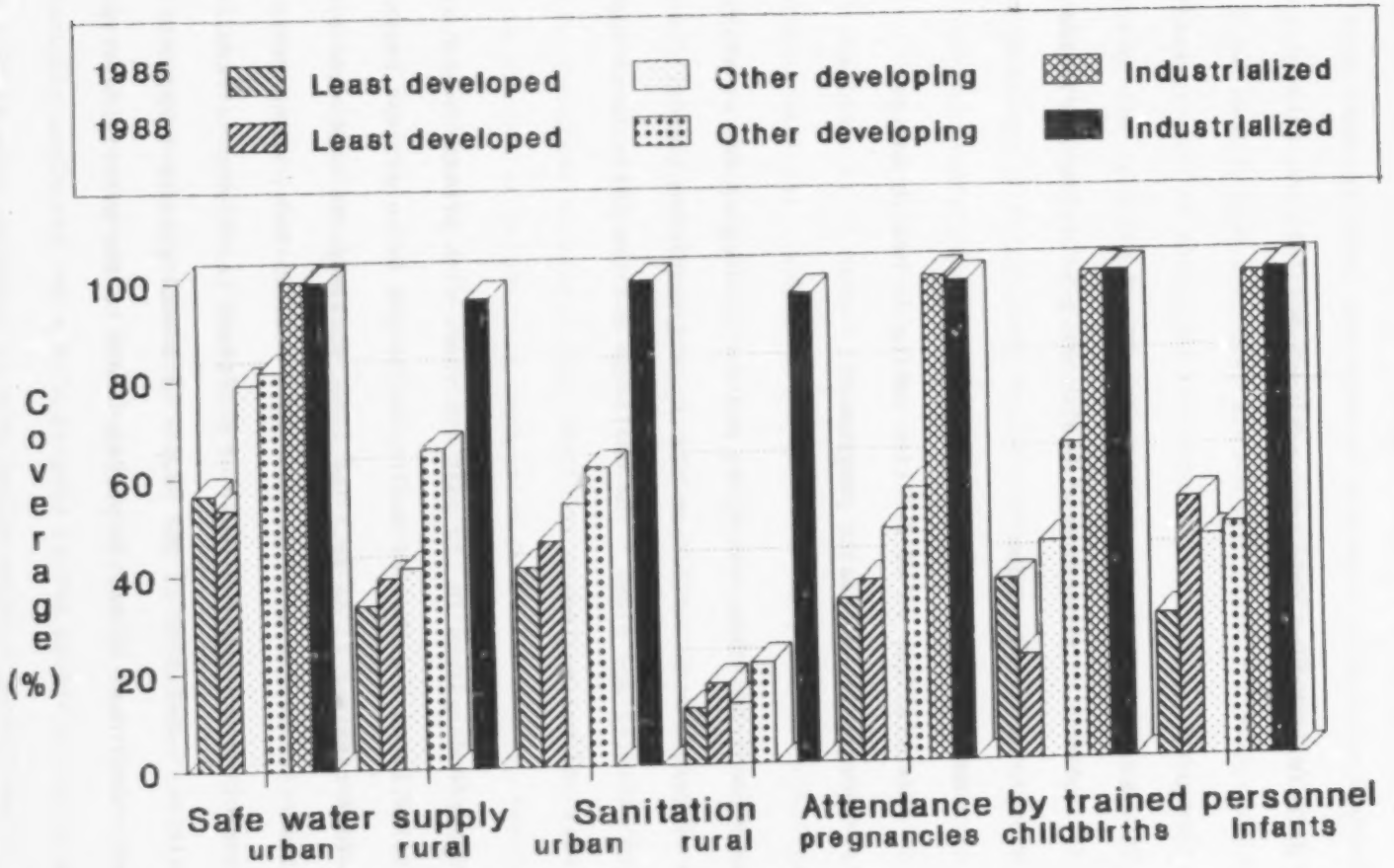
They must be active partners in their country's quest for future growth and development. To do so they must be healthy, well-nourished, educated and sheltered. The challenge of the 1990s for the LDCs and for the world as a whole will be to meet the basic needs of these children, women and men in health, nutrition, education and housing.

Meeting basic needs in health continues to elude LDCs. During the 1980s there has been a decrease in the supply of and an increase in the demand for health services. This imbalance is unacceptable. The gap in health status (as shown by selected indicators (see graph overleaf)) between LDCs and other developing countries on the one hand and developed countries on the other reflects this. To close this gap, it is clear that the 1990s call for considerable investment in health in least developed countries.

In the decade ahead the concepts and principles of primary health care, as envisaged by governments in Alma-Ata in 1978 and recently reaffirmed at Riga, USSR in March 1988, remain viable. The essential elements of primary health care include:

1) information and education concerning health
2) promotion of food availability and proper nutrition
3) water and sanitation
4) maternal and child health
5) immunization

Weighted average of selected indicators by level of development of countries 1985* and 1988*



* date of report

6) prevention and control of endemic diseases

7) treatment of common diseases and injuries

8) provision of essential drugs.

The principles behind this approach include:

1) equity

2) accessibility to health care by all

3) emphasis on promotion of health and prevention of disease

4) intersectoral action

5) community involvement

6) decentralization of decision-making in health matters

7) integration of health programmes.

In most countries these concepts, and the strategies for attaining them, have been expressed with sufficient clarity and operational detail in national health policies and plans. The challenge for the 1990s is to implement these policies and strategies.

Experience gained in the past ten years with primary health care points specifically to a number of health challenges to be met and indicates the resources required to do so. The first challenge is to ensure a sustained commitment to health development. This will include, among other factors, commitment at the highest level of political leadership to reduce social inequities; commitment of the people to assume greater responsibility for their health; commitment of health professionals to the principles of primary health care.

The second challenge is the need to intensify efforts to strengthen the health infrastructure, based on the principles of primary health care. This will require particular attention to adequate manpower, skills, technology, resources (at each level of care) and referral systems. Particular emphasis is needed at the community and district levels. The effects of population growth and the demand for health care resources are already great and will continue to be so. New diseases such as AIDS, and the recrudescence of old ones such as malaria, influence the existing health infrastructure. Many countries, at all levels of development, do not fully realize or take advantage of the cost-effective measures of the primary health care approach; in many countries, for example, over-concentration on hospital-based care has increased.

The third challenge is to ensure the optimum use of all resources available for health (human, material, technological and financial) and the mobilization of additional ones. There is still a large gap in the spending levels for health between developed and developing countries and, while spending levels alone are not the only measure of efforts needed to improve health levels, there should be a minimum threshold that countries ought to be able to sustain. It is clear that maintaining past gains in health status, especially in least developed countries, will require resource levels of a much higher magnitude that at present. For the majority of countries (at least 65% of the world's population) spending levels on health are within the range of 1%-3% of GNP. Finding new ways to cope with new economic realities requires creativity and political skill in order to increase the participation of individuals and communities, non-governmental organizations and the private sector in a spirit of partnership with governments. Health personnel should be technically qualified, socially motivated and should respond to the people's health and social needs. It is also important to give health workers incentives to

deliver good care economically. Strengthening of health research and development will be a very significant form of support for the implementation of national health strategies.

The fourth challenge is to intensify efforts to strengthen managerial capabilities including measures to ensure sound decisions and policies, with a sharper focus on priorities and targets based on valid information. National capacities for assessing and projecting health needs and tasks on a continuing basis, as well as for developing or reorientating health strategies and programmes, and for the monitoring and evaluating of their progress and outcome, will require considerable strengthening. The capacity of ministries of health to carry out an economic analysis of health choices will need enhancing.

Looking ahead to the coming decade, the real resources required for the health sector and for related health actions will be significantly greater than in the past decade. There is an optimum amount that countries and individuals should spend so as to maximize health improvements, but it is difficult, if not impossible, to quantify with precision that figure. On a world average scale, less than 5% of GNP is spent on health care services, with some countries at close to 12% and others at less than 2%. As a minimum, in the next decade, the percentage of GNP devoted to health should probably be doubled in some countries. Much of this increase should be for previously neglected health problems presenting a heavier socioeconomic burden for society. In the affluent countries, historic rates of economic growth will generate sufficient resources in the future, although even there reforms in delivery and finance systems will be necessary. In the poor and developing countries, a shift in priorities with more emphasis on primary health care would help liberate some

of the resources needed. Reforms of financing and delivery systems would also result in internal resources becoming available for reallocation towards priority health concerns. However, for human development and health levels to increase over the next decade in the least developed countries it will require favourable world economic conditions and major reforms in management, delivery and financing. In addition, LDCs will require adequate additional, external financial assistance for the foreseeable future.

IMPLEMENTING PRIMARY HEALTH CARE: PROPOSALS FOR ACTION IN THE 1990s

The basic strategic health objectives for the 1990s continue to be the attainment of targets set and adopted by governments at Alma Ata in 1978 and reaffirmed at Riga, USSR in 1988. Detailed analysis of global indicators for monitoring the progress toward the achievement of these targets, based on information provided by the countries themselves, is set out in Annex 1.

Achieving the effective implementation of primary health care requires partnership among least developed countries, the World Health Organization and the members of the international community. It is essential that each partner in this cooperation takes specific responsibilities and action.

ACTIONS BY THE LDCs

Health should be considered as everyone's business. This will require political commitment at the highest level including ministries of planning and finance as well as the ministries of education and health. An enabling environment that promotes effective and efficient health care delivery

including appropriate incentives and building up a physical infrastructure must be created. This building of capacity and investing in people to improve the delivery of health services will be essential. While developing this capacity, the process of decentralization within the decision-making system to increase responsiveness to the needs of the people and facilitate local participation in planning and implementation of activities should be stressed. While recognizing the special economic characteristics of the health sector, it should be perceived as an economically productive sector and as such should be able to compete for adequate government domestic resources. Finally, having developed the appropriate priorities and strategies, the government should ensure that all external partners collaborate within this framework to ensure that external inputs would best complement domestic expenditure.

ACTIONS BY DONOR GOVERNMENTS

It must be recognized that LDCs will require adequate additional external financial support on a long-term basis and that fundamental changes in aid modalities for the health sector are required, both to limit LDC dependence and to increase the effectiveness of aid.

International policies could be developed to ensure that both multilateral and bilateral partners work within a common framework to strengthen governments in attaining their health sector priorities. Joint programming by donors in full consultation with the government and in coordination with the World Health Organization would improve aid coordination. In order to improve intersectoral technical cooperation to absorption, local and recurrent cost support should be increased. The role of NGOs in enhancing absorptive capacity should be recognized.

External assistance should be consistent and continuous. Multiple year programming of assistance would help to improve predictability.

ACTIONS BY WHO

WHO has launched a new initiative aimed at overcoming the obstacles to the effective implementation of primary health care, where the concentration of effort is on countries and peoples in most need.

This initiative, which is country focused, emphasises better integration and coordination of all WHO programmes within a country, together with close alignment of WHO activities with the national priorities in health. It also lays special stress upon the need to support countries in developing an increased capacity to deal with the analytical, management, economic and financial aspects of health strategies.

Inherent in the WHO approach is a commitment by the national authorities of the country concerned to take a fresh and realistic look at their health priorities and available resources, and to do this within the concept of starting from a zero base. The government concerned must be prepared to recast its national health plans, or to vary them, and to reallocate existing resources, if the reappraisal shows this to be necessary.

At the same time, WHO in consultation with the government concerned must commit itself to a re-examination of the allocation pattern of its own resources, with a view to ensuring appropriate redeployment of such resources as required.

The outcome of this process will naturally vary from country to country. However, in most cases it can be anticipated to lead to the development of better integrated, well coordinated and more realistic national health development plans, as well as health systems and infrastructure development, which face up to the realities of the availability of human and financial resources.

In pursuing the new initiative, each of the WHO organizational levels (global, regional and country) has a vital and complementary role to play. While headquarters retains responsibility for overall policy, provides appropriate technical support together with the regional offices, and plays a major role in seeking and coordinating additional resources for the initiative, the regional offices are the crucial focus for the coordination and management of the ongoing activities of the initiative within the countries of their regions. Within each country the role of the WHO representatives (WR), as coordinators of all WHO in-country programmes, is of utmost importance for the success of the new endeavour. WHO is exploring ways of strengthening the capacity of the Office of the WR to support more effectively the ministry of health in technical areas and play a full and active role as coordinator in the international health field. The new initiative, with its emphasis on better integration at country level and on a more effective WHO country office, offers an excellent launch-pad for more effective and mutually beneficial working relationships at country level between WHO and cooperating agencies.

An important result of the activities under the initiative will be an increased capacity for planning, programming and management in the health sector. This will, of course, be of direct benefit to the countries concerned, but it will also provide a guarantee of a greater capacity to absorb, and to use effectively, resources provided, both from other cooperating organizations and WHO.

In summary, the development by the national authorities, of rational, realistic and coherent health plans, taking into account the realities of resource availability, provides a logical framework with which resources will be used more effectively and as part of the overall development process of the country.

Throughout the process described above, the Organization will maintain, at all levels, a close working partnership with multilateral and bilateral development cooperation agencies. Inherent in the new approach is the recognition of the government as the national body responsible for the coordination of external cooperation in the health field and for the integration of such cooperation into a cohesive national plan. WHO will cooperate with ministries in strengthening their capacity in this respect. Emphasis should be placed on the definition of a framework for cooperation which would be based on the national health plan and would include an analysis of the conditions required by all partners involved as well as an evaluation scheme. Governments should be supported in ensuring that all external partners then operate within that framework. The objective is to mobilize appropriate national and external resources to fill any identified resource gap and thus ensure that priority programmes and activities are financed. WHO should

support governments in developing an analytical ability to forecast resource needs, to justify these needs, to predict resource availability and to assess the impact and effectiveness of cooperation received. The Organization should also support governments in their efforts to mobilize resources and coordinate aid by such means as helping to develop a health cooperation strategy and participating in the relevant negotiations, and through the provision of technical and logistic support for meetings with the financing agencies.

This initiative for intensified cooperation with countries should result in cooperation in health being more effective, efficient, timely and appropriate to the problems of each country. There is, at present, no other choice in the global endeavour to meet the challenge posed by the persistance of high mortality and preventable morbidity in least developed countries. Through a better integrated and more sharply focused approach to primary health care implementation by countries, WHO and the international community will open the door to significant advances in the health status of the peoples in least developed countries.

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ANNEX 1

COUNTRY OR AREA	Immunization of infants (% coverage for 1985* - 1988*)								Immunization of pregnant women tetanus (2d)#	
	DPT		Measles		Poliomyelitis		BCG			
	1985	1988	1985	1988	1985	1988	1985	1988	1985	1988
AFGHANISTAN	15	25	14	31	15	25	17	27	11	6
BANGLADESH	2	9	1	6	2	8	2	14	2	7
BENIN	17	52	23	38	16	52	27	67		8
BHUTAN	10	27	11	23	11	27	21	38	3	10
BOTSWANA	68	86	68	91	68	88	68	99		40
BURKINA FASO		34	38	68		34	17	67	4	26
BURUNDI		73		58		76		89	18	49
CAPE VERDE		45		59		58		99		
CENTRAL AFRICAN REPUBLIC	20	24	23	30	20	24	34	53		20
CHAD		13		16		13		31		15
COMOROS		71	18	71		73		97	10	26
DEMOCRATIC YEMEN	7	25	14	35	7	25	17	41	3	8
DJIBOUTI	30	60	27	61	30	60	58	42	10	10
EQUATORIAL GUINEA	3	3	12	12	4	4		29	17	17
ETHIOPIA	6	16	12	13	6	6	11	27	4	7
GAMBIA	77	77	75	82	55	83	92	90	83	85
GUINEA		2		9		1		6		7
GUINEA-BISSAU	18	56	35	60	18	54	33	98	10	22
HAITI	19	28	21	23	19	28	57	45		31
KIRIBATI	37	37	7	7	15	15	49	49		2
LAO PEOPLE'S DEMOCRATIC REPUBLIC	28	71	33	70	28	71	8	77		62
LESOTHO		77		79		77		84		0
MALAWI	52	55	51	53	46	50	87	92	18	20
MALDIVES	3	6	30	9	5	6	52	60	15	2
MALI		3		5		3		15		3
MAURITANIA		32		69		61		91	12	0
MOZAMBIQUE	29	29	39	39	25	25	47	47	40	40
MYANMAR	16	23		14	3	13	45	45	20	24
NEPAL	31	46	45	0	20	40	67	78	10	15
NIGER		5		0		0		0		3
RWANDA	50	67	52	78	56	86	83	92	21	0
SAMOA	92	89	89	81	92	93	97	97		21
SAO TOME AND PRINCIPE	42	66	35	59	45	65	75	90	42	59
SIERRA LEONE		30		50		30		73		59
SOMALIA	22	25	34	29	22	25	31	33	14	6
SUDAN	8	29	6	22	8	29	12	46	3	12
TOGO		41		48		40		66		64
TUVALU	97	58	92	65	97	73	99	92		13
UGANDA	14	39	17	48	13	40	37	74	5	13
UNITED REPUBLIC OF TANZANIA	67	81	74	88	64	65	90	94	37	54
VANUATU	30	31	26	25	27	31	83	75		16
YEMEN	10	14	11	15	10	14	20	28	3	2
Average of countries reporting both years	31	42	33	44	28	41	48	63	17	23

Source: WHO/EPI figures as of 1985 and 1988

* date of report

\# 2 doses

COUNTRY OR AREA	Attendance by trained personnel (%)					
	Pregnancies		Childbirths		Infants	
	1985*	1988*	1985*	1988*	1985*	1988*
AFGHANISTAN	5.0	8.0	5.0	8.0		
BANGLADESH		12.0		5.0		
BENIN	27.2	63.7	34.3	44.6		
BHUTAN	3.4	16.0	3.4	7.0		38.0
BOTSWANA		74.0		79.0		54.0
BURKINA FASO	40.0	10.3		30.0	30.0	20.0
BURUNDI	13.6	30.0	12.0	16.0	14.2	
CAPE VERDE	96.0	99.0	10.0		85.0	100.0
CENTRAL AFRICAN REPUBLIC		68.5		65.7		67.6
CHAD						
COMOROS	69.4	69.4	24.0	24.0		
DEMOCRATIC YEMEN	10.0	10.0	10.0	10.0		
DJIBOUTI	50.0	76.0	73.0	79.0	15.0	62.0
EQUATORIAL GUINEA						
ETHIOPIA	14.0		58.0	9.0	10.0	15.0
GAMBIA	90.0	90.0	80.0	54.0		
GUINEA		36.0		25.0		
GUINEA-BISSAU		29.0		38.7		92.5
HAITI	44.8	41.0	20.0	40.0		33.0
KIRIBATI						
LAO PEOPLE'S DEMOCRATIC REPUBLIC						
LESOTHO	40.0	50.0	28.0	40.0		80.0
MALAWI	73.8	37.0	58.6	45.0	64.0	98.0
MALDIVES	47.0					
MALI		20.0		16.0		
MAURITANIA	58.0	26.5	22.6	20.0	60.0	47.0
MOZAMBIQUE	46.0	43.0	28.0	30.0	17.0	23.0
MYANMAR	90.9	75.0	97.4	25.0		71.0
NEPAL	17.0	9.0	10.0	6.0	10.0	
NIGER	46.5		46.5		17.9	
RWANDA		85.0		22.0		
SAMOA	92.0	50.0	52.0	95.0	97.0	50.0
SAO TOME AND PRINCIPE	60.0	64.0		86.0	3.5	80.0
SIERRA LEONE	30.0		25.0		30.0	
SOMALIA	2.0	2.0	2.0	2.0		
SUDAN	20.0	40.0	20.0	60.0	70.0	70.0
TOGO						
TUVALU	100.0	100.0	100.0	100.0	100.0	100.0
UGANDA		86.0				
UNITED REPUBLIC OF TANZANIA	98.0	90.0	74.0	60.0		90.0
VANUATU	90.0	75.0	72.0	86.0		
YEMEN	21.0		12.0	12.0		
Average of countries reporting both years	51.5	49.0	39.0	37.9	50.1	60.5

Source: WHO country monitoring and evaluation reports

* date of report

COUNTRY OR AREA	GNP/GDP per capita US$	
	1985*	1988*
AFGHANISTAN	202	205
BANGLADESH	123	147
BENIN	290	349
BHUTAN	80	110
BOTSWANA	648	1500
BURKINA FASO	240	200
BURUNDI	180	240
CAPE VERDE	341	
CENTRA'. AFRICAN REPUBLIC	280	
CHAD	80	158
COMOROS	300	300
DEMOCRATIC YEMEN	408	430
DJIBOUTI	276	276
EQUATORIAL GUINEA	180	
ETHIOPIA	120	
GAMBIA	250	
GUINEA	300	320
GUINEA-BISSAU	160	200
HAITI	300	330
KIRIBATI		324
LAO PEOPLE'S DEMOCRATIC REPUBLIC	202	202
LESOTHO	623	400
MALAWI	262	170
MALDIVES	407	348
MALI	120	170
MAURITANIA	185	235
MOZAMBIQUE	270	105
MYANMAR	170	239
NEPAL	170	160
NIGER	240	250
RWANDA	236	301
SAMOA		299
SAO TOME AND PRINCIPE	264	
SIERRA LEONE	320	300
SOMALIA	290	270
SUDAN	375	105
TOGO	264	
TUVALU	360	334
UGANDA	230	164
UNITED REPUBLIC OF TANZANIA	270	270
VANUATU	529	115
YEMEN	530	520
Average of 33 countries reporting both years	284	286
Range	80 - 648	105 - 1500

Source: WHO country monitoring and evaluation reports, 1985 and 1988

* date of report

COUNTRY OR AREA	Adult literacy rates			
	Males		Females	
	1985*	1988*	1985*	1988*
AFGHANISTAN	33.0	50.0	6.0	10.0
BANGLADESH	39.7		18.8	
BENIN	25.1		9.5	
BHUTAN	36.8	36.8	10.0	10.0
BOTSWANA	32.0	62.0	36.0	64.0
BURKINA FASO	18.0	16.6	5.0	6.3
BURUNDI	35.4	46.0	15.7	35.0
CAPE VERDE	54.0		34.0	
CENTRAL AFRICAN REPUBLIC				
CHAD	35.0		8.0	
COMOROS		56.3		41.5
DEMOCRATIC YEMEN		59.0		25.0
DJIBOUTI	34.0	34.0	14.0	14.0
EQUATORIAL GUINEA				
ETHIOPIA				
GAMBIA		20.0		20.0
GUINEA	35.0		14.0	
GUINEA-BISSAU				
HAITI		40.0		35.0
KIRIBATI				
LAO PEOPLE'S DEMOCRATIC REPUBLIC				
LESOTHO		50.0		50.0
MALAWI	48.0	52.0	25.0	31.0
MALDIVES	81.5		81.8	
MALI	19.0		8.0	
MAURITANIA				
MOZAMBIQUE	44.2		12.3	
MYANMAR	86.0	85.8	76.0	71.6
NEPAL	31.7	51.8	9.2	18.0
NIGER	14.0		6.0	
RWANDA	49.5	61.0	30.5	33.0
SAMOA				
SAO TOME AND PRINCIPE	73.2		42.5	
SIERRA LEONE	31.0	32.0	17.0	25.0
SOMALIA	61.0	18.0	48.0	7.0
SUDAN	44.0	47.0	17.0	20.0
TOGO	33.0		20.0	
TUVALU				
UGANDA	63.0		38.0	
UNITED REPUBLIC OF TANZANIA			18.0	
VANUATU				
YEMEN	16.0	42.0	1.0	7.0
Average of 14 countries reporting male & 14 countries reporting female rates for both years	39.7	45.4	22.2	25.1
RANGE: minimum	14.0	16.6	1.0	6.3
maximum	86.0	85.8	81.8	71.6

Source: WHO country monitoring and evaluation reports, 1985 and 1988

* date of report

COUNTRY OR AREA	Population (in thousands) 1980	1985	1990
AFGHANISTAN	16,063	14,519	16,557
BANGLADESH	88,219	101,147	115,593
BENIN	3,494	4,050	4,741
BHUTAN	1,245	1,362	1,516
BOTSWANA	902	1,078	1,285
BURKINA FASO	6,959	7,882	9,007
BURUNDI	4,100	4,721	5,451
CAPE VERDE	296	330	379
CENTRAL AFRICAN REPUBLIC	2,298	2,576	2,913
CHAD	4,477	5,018	5,678
COMOROS	381	444	519
DEMOCRATIC YEMEN	1,861	2,137	2,491
DJIBOUTI	300	350	406
EQUATORIAL GUINEA	352	392	440
ETHIOPIA	38,750	42,271	46,743
GAMBIA	641	745	858
GUINEA	5,407	6,075	6,876
GUINEA-BISSAU	809	889	987
HAITI	5,413	5,922	6,504
KIRIBATI	59	64	68
LAO PEOPLE'S DEMOCRATIC REPUBLIC	3,205	3,594	4,071
LESOTHO	1,339	1,538	1,774
MALAWI	6,091	7,141	8,428
MALDIVES	155	183	215
MALI	7,023	8,082	9,362
MAURITANIA	1,551	1,766	2,024
MOZAMBIQUE	12,100	13,720	15,663
MYANMAR	33,821	37,544	41,675
NEPAL	14,858	16,915	19,143
NIGER	5,311	6,115	7,109
RWANDA	5,163	6,102	7,232
SAMOA	155	163	170
SAO TOME AND PRINCIPE	85	97	112
SIERRA LEONE	3,263	3,665	4,151
SOMALIA	5,352	6,398	7,555
SUDAN	18,681	21,818	25,195
TOGO	2,554	2,960	3,455
TUVALU	8	8	9
UGANDA	13,119	15,491	18,442
UNITED REPUBLIC OF TANZANIA	18,867	22,751	27,328
VANUATU	117	142	164
YEMEN	5,995	6,888	8,017

Source: UN - World Population Prospects, 1988

COUNTRY OR AREA	Life expectancy - Males			Life expectancy - Females		
	1980-1985	1985-1990	1990-1995	1980-1985	1985-1990	1990-1995
AFGHANISTAN	40.0	41.0	43.0	41.0	42.0	44.0
BANGLADESH	49.1	51.1	53.1	48.1	50.4	52.6
BENIN	42.4	44.9	46.9	45.6	48.1	50.2
BHUTAN	46.6	48.6	50.6	45.1	47.1	49.4
BOTSWANA	53.0	55.5	58.0	59.0	61.5	64.0
BURKINA FASO	43.7	45.6	47.6	46.8	48.9	50.9
BURUNDI	44.9	47.4	49.3	48.1	50.7	52.7
CAPE VERDE	57.3	59.3	61.3	60.8	62.8	64.8
CENTRAL AFRICAN REPUBLIC	41.4	43.9	45.9	44.6	47.1	49.1
CHAD	41.4	43.9	45.9	44.6	47.1	49.1
COMOROS	48.3	50.3	52.2	51.7	53.8	55.8
DEMOCRATIC YEMEN	46.9	49.4	51.9	49.9	52.4	54.9
DJIBOUTI	43.4	45.4	47.4	46.6	48.7	50.7
EQUATORIAL GUINEA	42.4	44.9	46.9	45.6	48.1	50.1
ETHIOPIA	38.4	39.4	41.4	41.6	42.6	44.6
GAMBIA	39.4	41.4	43.4	42.6	44.6	46.6
GUINEA	38.7	40.6	42.6	41.8	43.8	45.8
GUINEA-BISSAU	41.4	43.4	45.4	44.6	46.6	48.7
HAITI	51.2	53.1	55.0	54.4	56.4	58.3
KIRIBATI						
LAO PEOPLE'S DEMOCRATIC REPUBLIC	44.5	47.0	49.5	47.5	50.0	52.5
LESOTHO	49.0	51.5	54.0	58.0	60.5	63.0
MALAWI	44.4	46.3	48.4	45.7	47.7	49.7
MALDIVES						
MALI	40.4	42.4	44.4	43.6	45.6	47.6
MAURITANIA	42.4	44.4	46.4	45.6	47.6	49.7
MOZAMBIQUE	42.9	44.9	46.9	46.1	48.1	50.2
MYANMAR	55.8	58.3	60.8	59.3	61.8	64.3
NEPAL	49.0	51.5	54.0	47.5	50.3	53.0
NIGER	40.9	42.9	44.9	44.1	46.1	48.1
RWANDA	44.9	46.9	48.8	48.1	50.2	52.2
SAMOA						
SAO TOME AND PRINCIPE						
SIERRA LEONE	37.5	39.4	41.4	40.6	42.6	44.6
SOMALIA	41.4	43.4	45.4	44.6	46.6	48.6
SUDAN	46.6	48.6	50.6	49.0	51.0	53.0
TOGO	48.8	51.3	53.2	52.2	54.8	56.8
TUVALU						
UGANDA	47.4	49.4	51.4	50.7	52.7	54.7
UNITED REPUBLIC OF TANZANIA	49.3	51.3	53.3	52.7	54.7	56.7
VANUATU						
YEMEN	46.9	49.5	52.0	49.9	52.4	54.9
Average of 36 countries	45.1	47.2	49.3	48.0	50.2	52.3
Range: minimum	37.5	39.4	41.4	40.6	42.0	44.0
maximum	57.3	59.3	61.3	60.8	62.8	64.8

Source: UN - World Population Prospects, 1988

COUNTRY OR AREA	Infant mortality rates		
	1980-1985	1985-1990	1990-1995
AFGHANISTAN	183.0	172.1	162.4
BANGLADESH	128.2	119.2	107.5
BENIN	120.1	110.0	101.0
BHUTAN	138.7	128.2	118.2
BOTSWANA	76.0	67.0	58.0
BURKINA FASO	149.4	137.6	126.5
BURUNDI	124.1	111.9	102.7
CAPE VERDE	74.8	65.6	56.7
CENTRAL AFRICAN REPUBLIC	142.0	132.0	122.0
CHAD	142.8	132.0	122.0
COMOROS	88.3	79.8	71.7
DEMOCRATIC YEMEN	134.9	120.4	106.5
DJIBOUTI	132.0	121.6	111.9
EQUATORIAL GUINEA	137.3	127.0	117.0
ETHIOPIA	159.0	154.3	142.8
GAMBIA	154.3	142.8	132.0
GUINEA	159.1	147.4	136.2
GUINEA-BISSAU	142.8	132.0	121.6
HAITI	128.0	117.0	106.0
KIRIBATI			
LAO PEOPLE'S DEMOCRATIC REPUBLIC	122.5	110.0	97.0
LESOTHO	111.0	100.0	89.0
MALAWI	163.0	150.5	138.3
MALDIVES			
MALI	179.5	169.0	159.0
MAURITANIA	137.3	126.6	116.6
MOZAMBIQUE	153.5	141.5	130.1
MYANMAR	80.0	70.2	59.1
NEPAL	138.7	128.2	118.2
NIGER	145.7	134.6	124.1
RWANDA	132.0	121.6	111.9
SAMOA			
SAO TOME AND PRINCIPE			
SIERRA LEONE	166.5	154.3	142.8
SOMALIA	142.9	132.0	121.7
SUDAN	117.6	108.1	99.1
TOGO	102.3	93.8	85.3
TUVALU			
UGANDA	112.0	102.7	93.8
UNITED REPUBLIC OF TANZANIA	115.0	105.6	96.6
VANUATU			
YEMEN	129.9	115.7	102.3
Average of 36 countries	132.3	121.7	111.3
Range: minimum	74.8	65.6	56.7
maximum	183.0	172.1	162.4

Source: UN - World Population Prospects, 1988

COUNTRY OR AREA	Coverage with safe water (%)				Coverage with adequate sanitary facilities (%)			
	Urban		Rural		Urban		Rural	
	1985*	1988*	1985*	1988*	1985*	1988*	1985*	1988*
AFGHANISTAN	30	38	10	17		5		0
BANGLADESH	29	25	43	66	21	20	2	6
BENIN	45	79	9	35	45	60	4	10
BHUTAN	40	100	14	24		100		7
BOTSWANA	98	100	72	33	79	90	13	25
BURKINA FASO	50	0	26	0	38	38	5	5
BURUNDI	33	92	22	27	90	90	25	15
CAPE VERDE	99	100	21	49	36	41	9	0
CENTRAL AFRICAN REPUBLIC	24	0	5	0	36	0	9	0
CHAD	27	0	30	0		0		0
COMOROS	99	0	52	0		90		80
DEMOCRATIC YEMEN	73	86	39	35	69	70	33	30
DJIBOUTI	53	50	20	21	43	94	19	50
EQUATORIAL GUINEA	47	0		0	28	0		0
ETHIOPIA	93	0	42	0		0	5	0
GAMBIA	100	0	33	0		0		0
GUINEA	91	62	2	15	54	0	1	0
GUINEA-BISSAU	21	19	37	22	21	29	13	18
HAITI	73	59	25	32	54	42	12	14
KIRIBATI		0		0		0		0
LAO PEOPLE'S DEMOCRATIC REPUBLIC		0		0		0		0
LESOTHO	37	0	14	40	22	0	11	20
MALAWI	82	66	54	49		0		0
MALDIVES	53	91	8	17	69	100	1	2
MALI	58	48	20	17	90	100	5	0
MAURITANIA	80	0	16	0	7	0		0
MOZAMBIQUE	82	50	2	12		80		40
MYANMAR	36	37	21	27	34	35	15	26
NEPAL	71	77	11	24	16	54	1	1
NIGER	48	0	34	0	36	0	3	0
RWANDA	55	0	60	0	60	0	60	0
SAMOA		0		0		0		0
SAO TOME AND PRINCIPE		0		0		0		0
SIERRA LEONE	58	86	8	20	43	86	10	20
SOMALIA	60	57	20	22	60	44	5	5
SUDAN		90		20	20	40	1	5
TOGO	68	0	26	0	34	0	8	0
TUVALU	100	100	100	100				
UGANDA	45	45	12	12	40	40	10	10
UNITED REPUBLIC OF TANZANIA	85	80	47	38	91	90	76	78
VANUATU		0		0		95		35
YEMEN	100	90	21	30	75	66		0
Average of countries reporting both years	63	68	26	31	52	61	14	19

Source: WHO country monitoring and evaluation reports, 1985 and 1988

* date of report